

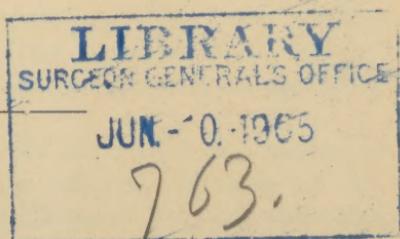
ROSENWASSER (M.)

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BY

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A Report from the Transactions of the Fifty-Second
Annual Meeting of the Ohio State Medical
Society held at Cleveland, O.



NORWALK, OHIO,
THE LANING PRINTING, CO.
1897.

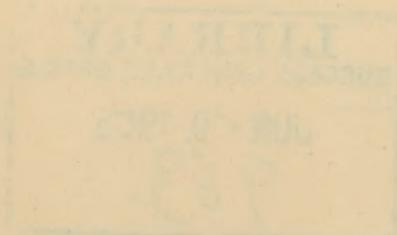
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CHAPTER VII.

A CASE OF INTRA-PERITONEAL GESTATION AT TERM, OPERATION AFTER DEATH OF FETUS—RECOVERY.

BY

M. ROSENWASSER, M. D., CLEVELAND.

On February 16th, 1897, I saw in consultation with Dr. G. R. Feil, a woman, who had then gone beyond term about two weeks and had gradually ceased feeling "life" after having suffered from false pains between February 1st and 3d. My advice was sought not on account of any suffering, but because husband and wife felt uneasy about the probable death of the child, and anxious to have terminated the pregnancy now overdue. Her physician had only recently been engaged to attend her, knew nothing of her previous history, and had no cause to suspect anything abnormal. He examined her in labor, heard the fetal heart very distinctly, found a slightly tinged discharge, the cervix soft, the os rigid and not dilatable, the pains short, sharp, exasperating. The pains proving ineffectual, he gave an anodyne for relief, as he regarded the attack merely a false alarm. By degrees the pains ceased and did not return.

When seen by me the patient, an undersized brunette, of healthy family, was in the kitchen attending to her household duties. She was 33 years old; married eight years; Ipara; the last child born five years ago; no abortions. Previous to her pregnancy her health had been good, her menses regular, the last period April 23, 1896.

She failed to "come round" in May, which so upset her plans, that she consulted a "doctor" who dilated the womb on June 13th. The attempted abortion caused the loss of a few drops of blood, but was followed by no further consequence. On June 23d, she was lying on the sofa. Suddenly she was seized with a most violent pain in the abdomen, fell to the floor and fainted. When she returned to consciousness she could not get up, but was carried to bed, and was confined for two weeks with supposed peritonitis. She remained weak all through the summer and fall. She did not feel life until the latter part of October, though she was told she was pregnant while on a visit in Buffalo late in August. She has never felt much motion. Since the spurious labor, she has positively diminished in size.

The contour and size of the abdomen correspond to an eight months' gestation. The enlargement consists of a large, smooth, round tumor filling the abdomen, except low down in the left hypogastrium where it crowds a smaller, harder tumor to be felt from the point of contact above the pubes to the extreme left in the iliac fossa. Fetal parts cannot be made out. There is no fluctuation. There are no movements, contractions, or fetal heart sounds. The cervix is soft, the external os admits the end of the finger, but the internal os is dense, will not admit of dilatation by the finger. A careful bimanual (repeated on different days), enables me to recognize the smaller tumor as the uterus, elongated and pushed to the extreme left by the larger tumor. The posterior vaginal vault is slightly bulged down, convex, filled with a doughy, tender, immovable mass.

The diagnosis of ectopic pregnancy originating in the right-tube, and of a dead fetus was foreshadowed by the history, and confirmed by the physical examination. It was decided to watch the patient and await indications for interference. On the eve of February 20th, Dr. F. was

called. The woman had felt chilly all day and had severe pain in the abdomen. Her temperature was 100.5° ; pulse ninety; abdomen quite tender, especially about the umbilicus. She was removed to the Cleveland General Hospital the following morning. The evening temperature was again 100.5° ; pulse ninety-eight; tenderness and pain constant. Operation set for the 22d.

Operation February 22d. Present: Drs. Feil, N. Stone Scott, Towslee, Bernstein and several private students. Anesthetic, chloroform. After the patient was anesthetized, the sound was introduced into the uterus. It entered five inches to the fundus in the direction of the long axis of the smaller tumor. The incision was median from the umbilicus downward, afterwards extended upward about three inches. The parietal peritoneum was much thickened and dark in color, not adherent to visceral contents. The gestation sac now presented. Across the upper part of the sac, which reached nearly to the liver, lay the infolded omentum. The latter was attached to the sac by recent adhesions. Upon gently loosening these the skin of the fetus became visible through the opening in the sac that had been plugged by the omentum. The loops of intestine surrounding the opening in the sac were intensely red. The opening was extended downward by an incision through the sac wall, disclosing the somewhat macerated, female fetus. The breech presented; the back of the child to the abdomen of the mother. The child was delivered; the funis clamped and cut. There was not a drop of amniotic fluid either in the sac or in the abdominal cavity. The amnion formed the innerlining of the sac. The boundaries of the gestation sac were now examined. It crowded the elongated uterus far to the left. It extended from the inner border of the left broad ligament, occupied the entire right pelvis and enclosed the lower abdomen forming a dome over the pelvic cavity. Above it was covered by adherent intestines. The lower anterior wall was formed

of uterus and broad ligament. The sac wall, except where the posterior surface of the uterus and of the broad ligament complemented it, was composed of organized lymph, its thinner portions readily breaking down. The intestinal adhesions were now relieved with the intention of extirpating the entire sac. There was no difficulty until the sigmoid flexure was reached. This was so intimately connected that to continue would be to risk gangrene of the gut. Extirpation was therefore abandoned. Behind and below the sac, adherent to the bottom of the recto-vaginal pouch was a mass as large as an orange, which on enucleation proved to be an organized blood clot. The placenta was attached within the anterior portion of the sac to the right margin and right posterior surface of the uterus. The detachment of the placenta was begun at the bottom of the sac and was quickly accomplished. Tufts of placental tissue and shreds of membrane were left in the sac. The hemorrhage was not at first severe and was controlled by a firm pack of hot gauze sponges. While stitching the sac wall to the abdominal incision, there was noticed a rapid bleeding through the pack. The sac was emptied and repacked, but the bleeding went furiously on. The left broad ligament was clamped. The tissues to the right of the sac were also clamped. The sac was repacked. The hemorrhage was now under control. Meanwhile my assistants had lowered the head of the blanched and all but pulseless patient, and made an intravenous transfusion of eight ounces of normal salt solution. The left ovarian artery was now ligated. The right ovarian and the uterines could not be reached. The clamps were removed, the edges of the sac were stiched to the parietal incision and as there was no bleeding, the gauze packs were left undisturbed in the gestation sac. The vagina was firmly tamponed and a T bandage attached to the abdominal binder. The operation had lasted seventy-five minutes. The

following are the essential features of the post-operative history.

February 23d. Patient has rallied nicely from the shock.

February 24th. Symptoms of sepsis. Pulse 130-140. Abdomen much distended. Remove packing, discharge very offensive.

February 25th. Had a poor night. Restless; pulse 144. Vomited once, a dark fluid. Remove shreds of membrane and small pieces of placenta. Discharge from sac still very offensive.

February 26th. Pulse 126. Abdomen still much distended, but wound not offensive.

March 7. Has been steadily improving, but temperature varies from 100° to 101°. Remove a gauze sponge from the bottom of the sac that had been overlooked at the time the others were removed. From this time on convalescence was uneventful. She was kept in bed seven weeks to avoid a strain on ventral cicatrix, and left the hospital in excellent condition April 18th. On May 6th she menstruated. There was no pain. The menses were scant and lasted two days.

The fetus was twenty inches long and weighed six and one-half pounds. Its surface was macerated, the epidermis peeling off in large flakes. The bones of the skull were loose and flabby; the cranial contents were soft, fluctuating, as is usual in a macerated fetus. There was no deformity. An X-ray was taken by Dr. Scott.

Cases of extra uterine pregnancy gone to term are not plentiful. With better training in early diagnosis, and with early removal of the products of gestation, such cases will become less frequent than at present. "During the hurry and dread of a critical operation," as Parry graphically expresses it, some of the details of the case here recorded were not noted, much to our regret. Sufficient data are at

hand, however, to warrant the conclusion that our case is one of very rare occurrence and of unusual interest.

The attempted abortion deserves but a passing notice. It had no bearing on the subsequent history. It is evident that the right tube ruptured when the patient was two months pregnant. That the rupture was intra-peritoneal, is proven by the organized blood clot adherent in the rectovaginal pouch. Not until after spurious labor were there any symptoms of secondary rupture. "Cases of primary intra-peritoneal rupture are almost uniformly fatal, either from hemorrhage, or subsequent suppuration of the sac and peritonitis."^{*} In our case the intra-peritoneal hemorrhage did not prove fatal, nor did suppuration take place. The uninjured ovum, containing a living fetus, was partly or wholly expelled from the ruptured tube leaving the placenta in the tube. The ovum continued its development within the abdomen, surrounded by exsudate and blood serum. The gestation sac thus formed attachments to the blood clot anchored below, and to the intestines above, while the placenta continued its growth close to the uterus. The fetal membranes and organized lymph formed the only envelope of the fetus above the pelvic brim. After the spurious labor the fetus died, and the amniotic fluid was absorbed; the patient herself noted her diminution in size. There was a final rupture of the upper anterior sac wall a few days previous to operation, causing a localized peritonitis, which gave the direct indication for interference.

According to † Webster's classification our case is one of "Tubo-peritoneal gestation, in which escape of the foetus in the membranes takes place into the peritoneal cavity, the placenta remaining in the tube, and development continuing." Webster further says: "The first undoubted case of such a form of ectopic gestation was described by

^{*}Tait, "Diseases of Women and Abdominal Surgery." Vol. 1, p. 443.

† "Ectopic Pregnancy," p. 53.

me in a monograph published in 1892. Several of the older writers, and also recent ones, e.g., Kuster, Werth, and Berry Hart thought this form possible, while others denied its possibility, believing that rupture of the tube into the peritoneal cavity meant death to the mother, unless she were operated on."

Our case sustains the broad view of Tait as against the narrow opinion of Bland Sutton. The old theory of abdominal pregnancy, that it is caused by the development of an impregnated ovum dropped into the peritoneal cavity has been generally abandoned. It is now believed that "*all forms of extra-uterine gestation pass their primary stages in the Fallopian tube.*"[†] Tait's present explanation of the abdominal variety under consideration is to the effect that, "what have been called abdominal pregnancies are clearly exceptional cases where primary tubal rupture at the end of the third month has not proved fatal; where the extended placenta has made for itself visceral attachments wherever it has touched; or where secondary rupture of a broad ligament cyst has converted an extra-peritoneal ectopic gestation into one within the peritoneal cavity."[§] Sutton || dissents as follows: "This view (of Tait) I cannot bring myself to accept. I am of opinion that these so-called abdominal pregnancies are primary tubal; gradually the tube opens out into the broad ligament, and as it progresses to term the walls of the gestation sac rupture, and the foetus escapes into the peritoneal cavity, as in the remarkable case recorded by Jessop." In other words Sutton believes that all such pregnancies have continued their development within the broad ligament until late in the gestation, when rupture of the broad ligament allowed the escape of the fetus into the abdominal cavity.

[†] J. Bland Sutton. "Surgical Diseases of the Ovaries and Fallopian Tubes." p. 344.

[‡] "Lectures on Ectopic Gestation," 1888, p. 13.

^{||} Op. Cit., p. 345.

The cases of Jessop, Champneys and Taylor, cited by Sutton in support of his views, differ in this essential from our own, that the foetus lay free among the intestines in the abdominal cavity without any membranous envelop; the foetus having but recently escaped from the gestation sac. The gestation sac in our case was not broad ligament, but the membranes of the ovum fortified by organized exsudate. The fetus was not free among the intestines, but was enclosed within the gestation sac.

DR. J. F. BALDWIN, Columbus: A case was sent into the Protestant Hospital, of Columbus, some two years ago, that is of interest as bearing on this question. During my absence from the city a woman was brought in moribund from peritonitis. The previous history was entirely negative, but the peritonitis was very evident. She died a few hours later. At the post-mortem the uterus and the appendages were found perfectly normal, but in Douglas's cul-de-sac was a ruptured gestation sac, and a fetus was lying in the cul-de-sac in a mass of blood. Now to say that in a case like this we had primarily a tubal pregnancy, and that the fetus and its membranes were expelled from this tube, dropped into Douglas's cul-de-sac and there contracted fresh adhesions, is clearly a begging of the question. There was nothing in the appearance of the tubes to indicate any such an occurrence. It looked like a case of primary abdominal pregnancy, as if the ovum itself had simply, after fecundation, dropped into the cul-de-sac, contracted adhesions and gone on developing for ten or twelve weeks.

DR. ROSENWASSER: I would suggest to Dr. Baldwin that it could just as easily have been a case of tubal abortion. In the meantime the tube might have completely recovered from the pregnancy, before the Doctor had an opportunity to perform the autopsy. That is the usual case in these cases. The impregnated ovum could be discharged from the abdominal end of the tube into the abdominal cavity, fall down into the cul-de-sac of Douglas, form attachments and afterwards undergo rupture. Thus we might explain the case without going out of the theories at present usually accepted.

DR. BALDWIN: The question as I understand it is, do we have original, primary abdominal pregnancy? If every case in which such a pregnancy is found at the autopsy is to be explained as having had its origin in a tubal pregnancy when nothing in the condition of either tube warrants such an inference, the advocates of this explanation are simply begging the question and placing it outside of all discussion.

DR. W. J. MEANS, Columbus. I have been very much interested in the paper read by Dr. Rosenwasser. The case reported is almost identical with one that I operated last December. The history of my case indicated a gestation of sixteen months. The lady ceased to menstruate in May, 1895. Three months later she had an attack of severe pains that made her apprehensive of a mis-carriage; after this, she continued to increase in size similar to a normal pregnancy; she went on to full term, and at the expected time sent for her physician thinking she was in labor; the pains were regular and in every way significant of coming labor, but after a few hours ceased, and from that time on she had no further trouble, and remained about the same size.

Several physicians were consulted, and various opinions given her as to the cause of the enlargement. She was brought to me in December. I examined her carefully and was satisfied that the case was one of ectopic pregnancy. The following day I operated and removed a foetus, fully developed, weighing seven pounds. There was slight maceration of the integument, and degeneration of the appendages, the amniotic fluid was thick and muddy. There had been some peritonitis, probably occurring about the third month, at the time that she suffered from the pains. The intestines were adhered very closely to the tumor, and required careful dissection to separate them.

After removing the child I made a complete hysterectomy, feeling it was the safest procedure. The patient made a very quick recovery, leaving the hospital in three weeks from the date of operation and has enjoyed good health ever since.

It is probable that in both cases there was a rupture of the fallopian tube about the time the patients were experiencing the acute abdominal pains. These cases present some interesting points both physiological and pathological,

which have been ably discussed by the doctor. That the impregnated ovum can receive proper nourishment for its development outside of the womb is an established fact; where the impregnation takes place is not so well understood.